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ABSTRACT

This article includes excerpts from case studies of at-risk students. It discusses the basic conditions associated with being "at-risk," the high prevalence of at-risk students in rural areas, and the relationship of this phenomena to social structural changes, particularly in the rural United States. Necessary policy and social responses are proposed with suggestions as to how changes might be achieved within the context of a given rural community. School and community preventive and treatment services are detailed. The article discusses the need to address the "secondary" disability (the emotional overlay) of an at-risk handicapped student to facilitate effective intervention with the "primary" disability. The article concludes with a description of the need for systemic change including an emphasis on self-esteem education, appropriate preservice and inservice training, community-business-school partnerships, family involvement, and community education. This paper contains 16 references. (TES)

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Rural "At-Risk" Students-- Directions for Policy and Intervention

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Rural "at-risk" students-- Directions for policy and intervention

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Abstract

This article includes excerpts from case studies of at-risk students. It discusses the high prevalence of at-risk students in rural areas, the relationship of this phenomena to rural cultures, and basic conditions associated with being "at-risk." Necessary policy and social changes are described and how these can be achieved within the context of a given rural community. School and community preventive and treatment services are detailed. The article discusses the need to address the "secondary" disability (the emotional overlay) of an at-risk handicapped student to facilitate effective intervention with the "primary" disability. The article concludes with a description of the need for systemic change including an emphasis on self-esteem education, appropriate preservice and inservice, community-business-school partnerships, family involvement, and community education.

Introduction

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Case study excerpts

The following are excerpts from case studies developed as part of a project designed to enhance the self-esteem of at-risk students functioning in a mainstreamed environment. Vital information about the students has been changed to protect their identities. The project was conducted by staff of the National Rural and Small Schools Consortium (NRSSC) and the American Council on Rural Special Education (ACRES). Pre- and post-tests concerning the students' self-esteem were given to the students, their teachers, and the group facilitators. Pre- and post-interviews were also conducted with the principal and counselor. Pre- and post-measurements improved regarding student self-esteem and rates of school attendance. The students also reported academic improvements, a decrease in alcohol and drug use, and less frequent sexual activity. Curriculum content in the project was focused on:

- self-acceptance and change
- discovering individual goals
- being responsible for one's own behavior
- choices individuals have
- how people allow their thoughts to control them
- cooperation vs. the need to be "right"
- feelings–
  - identifying them
  - their importance regarding controlling one's life
  - effectively dealing with them
  - accepting things one doesn't like and changing what one can
- communication skills–
  - to say what is needed/wanted
  - to deal with angry people
  - to avoid manipulating others or being manipulated when one is angry, hurt, or sad
- individuals get what they expect (regarding achievements, rewards, joy, and disappointments)
- relationships with peers, parents, authority figures, and those of the opposite sex.

Marsha

Marsha is a short, attractive 12-year-old child. She constantly strives to be the center of attention while loudly popping bubble gum, distracting other children in the class, or doing seductive break dancing to attract a crowd. Her mother, an alcoholic, who experienced a very abusive childhood, "did not notice" that her boyfriends sexually abused Marsha from the time she was two years old. Marsha has never known the identity of her father. Although her mother has been a recovering alcoholic for five years, she finds herself unable to cope with Marsha's behavior problems, including those in school. Marsha has developed very effective skills in manipulating others and lies adroitly. She is of above-average intelligence, and her grades are poor. When asked what would make her happy, she replied that she wanted a boyfriend to give her a baby so that she would finally have someone to love her.

Cindy

Cindy, 12 years old, is a homely child with stunted growth, high intelligence, and poor grades. She has a visibly low self-concept, and rarely has eye contact with others. Her frequently inaudible voice reflects her lack of self-confidence. She hunches over to hide the fact that she has reached puberty. She desperately seeks friendship and sets herself up with peers who treat her abusively.

Most of the friends Cindy has made tell her that her father, who lives across town from Cindy, has made suggestive sexual comments to them. Cindy lives at home with her mother and her mother's boyfriend, who is 15 years younger than her mother. As her mother works the night shift, Cindy is primarily in the care of the boyfriend and spends a lot of time at his peers' homes. She casually mentions that they use a lot of drugs. The school counselor wonders if Cindy is being sexually abused by the mother's boyfriend. Cindy wants to move away from home and live with an aunt in another state. Cindy states that her recovering alcoholic mother continually tells her, "You think you won't be an alcoholic, but you will be because I am. There is no way to escape it." Her teachers do not feel that she is a capable student. The child protective services unit in her area has no authority to approve her moving in with her aunt without a court awarding custody to that individual.

Cindy's life goal is to be a psychologist and to help others.

Robert

Robert, at 12 years of age, is easily as large as a 16-year-old. For two years, he was so frequently accused by his peers of taking steroids that he decided to try it. He liked the results and has continued to do so. Robert's goal is to look like Sylvester Stallone and to please his father by being a successful wrestler. A sharp contrast to his size is his typical manner of dropping his head toward his chest and speaking in a very low tone of voice without eye contact with the person to whom he is speaking.

His family is upper middle class and very involved in religious activities. His mother frequently states that she doesn't feel that her children have any right to express any displeasure about their lives. Her father was an abusive alcoholic, and she feels that her children have "everything". She frequently states to the school counselor and a project facilitator that she wishes that she had never had any children. Robert's father remarks that he "just wishes Robert would get along with his family and at school." Although Robert's core teacher says that he is basically a "teddy bear," he has been involved in several attacks on his schoolmates. Teachers have stated that these were brought on by dares or taunting from other students. His mother took him to an emergency room last year when he put his hand through a glass window in a fit of anger at a family member. Robert states that he wishes his mother would "hug him" and that his parents would believe in him.

Robert has been classified as learning disabled and is mainstreamed at school. His grades are poor. His homeroom teacher has encouraged him to assume that he will not be able to be successful in academics. He remarked to Robert and a project facilitator that Robert should "be okay with that" and "find something else he <u>can</u> do well."

Robert has been convinced for two years that he was responsible for his cousin's death. He was illegally driving a car in which his cousin was a passenger when the car was hit by another driver and the cousin suffered a very painful death. The police report indicated that Robert was not responsible (even though he was illegally driving). Robert was so despondent over his guilty feeling, that he attempted suicide. He was not successful, and shot himself in the leg. He never told his parents; his friends simply sewed up the wound and he has successfully hidden it from his parents.

Lynn

Lynn is a 12-year-old who consistently exhibits hyperactive behavior. Both teachers and her peers find her difficult to be around because of her constant need for attention. She takes Ritalin, and is constantly eating candy. She misses her brother, who lives in another state with her father, and says that her mother is always "putting her down." The specific conversations she relates are clearly verbally abusive. She is so used to being perceived as unlovable that she sets herself up

(e.g., lies to her peers or otherwise creates conflict situations) so that she will be rejected by her peers. Lynn's teachers find her a highly frustrating, distracting element in their class, due to her hyperactivity. No one has taken away the large bag of candy that she carries to school each day full, and empties by 3:00 p.m. Lynn's goal is to live with her father's ex-girlfriend, whom she says is the only person who has ever been nice to her. She has not spoken to this individual in two years.

Carry

Carry, 12 years old, has been diagnosed by appropriate medical and educational personnel as having a severe hearing impairment. Her behavior is moody. Her grades are above average. She has written numerous notes to her peers and one to her teachers stating that she is considering attempting suicide. She reports that she has tried to do so in the past and has not been strong enough to carry out her wishes. Upon close observation, it becomes apparent that her hearing impairment is quite selective. With a great deal of fear, embarrassment, and shame, Carry confides that she has been repeatedly molested by her older brother since she was seven years old. She lives with her mother, and the brother and twin sister now live with her father. She is consistently disappointed that the local child protective services division assigns a case worker who is always "going to get to her case as soon as possible". She feels a great deal of guilt about sharing information about her molestation and is concerned about her twin sister being left in the home where her brother lives. She complains that her mother never listens to her because she and her boyfriend are "always too busy smoking pot." Carry has a penchant for complaining about stomach problems and other physical ailments that come and go, depending upon her emotional state. Carry's goal is to live somewhere other than with her mother or father.

Jose

Jose, 12 years old, is one of the smallest boys in his class. He rarely talks and looks embarrassed and shy when spoken to. Jose appears to be afraid of his father, an alcoholic, and relates that his father has abusive behavior towards his mother. Jose feels that he is a burden to his family and that his mother has too many concerns of her own to deal with Jose's. His core teacher's pre-test indicated that Jose is passive and "never counteracts me on anything, even though his follow-through is poor." Upon close observation, it is apparent that Jose is a very bright student and takes in all interpersonal interactions and information shared within a group. He is able to synthesize the process of the entire group with accuracy.

By the end of the self-esteem class, he states that he has learned how to keep his father from hitting him by using his new communication skills. His homeroom teacher states that Jose is "for the first time, willing to share with the class" and that she "is surprised how much he knows." Jose's goal in life is to have a job that will allow him to buy all of the video games that he desires.

Elaine

Elaine is a 14-year-old who frequently smokes cigarettes and pot. She has tried "most drugs," and says that even a cigarette, although "smoking is not cool," gives her relief from her problems. She has been home schooled in the past, has given public schools a semester trial, and now is electing to go back to home schooling. Her family is upper middle class. The school counselor suspects that her father is sexually abusing her, although there is no evidence that is substantial enough to report. Elaine is very cautious when discussing what goes on in her home. Elaine's goal is to drop out of school as soon as possible because school "does not meet any of her needs and is boring." Teachers report that Elaine's home schooling background has caused difficulties in her ability to succeed in public school.

Bonnie

Bonnie is a 13-year-old with a sharp tongue and unkempt appearance. She is only one of two female adolescents in the group who does not wear makeup and talk about her desire for a boyfriend. She consistently complains about her mother's boyfriend verbally abusing her and threatening to physically abuse her, even in front of her mother. Bonnie reports that her mother sides with her boyfriend. She states that she feels sorry for her mother because of the way her boyfriend treats her. She states much too frequently that she is "so glad that she and her mother get along so well," and that she "feels sorry for the other kids in the group because they don't get along with their parents." Bonnie repeatedly states that she doesn't have any problems and allows herself to feel hostility only toward her mother's boyfriend. Bonnie's goal is to become a veterinarian.

Mary

Mary, 13, is a fully physically developed female whose low socioeconomic family has moved from one temporary housing site to another. Her mother has been living with a man of another race for two years, who died of cancer during the course of the group. Mary said on the day of his death that she "didn't feel anything, I just want to have some fun." Her core teacher wishes Mary would be more "ladylike," and thinks that is her greatest problem. Mary's goal is to have enough money to buy some clothes that she likes.

Polly

Polly is an unusually attractive 14-year-old who wears a great deal of makeup and is exceptional in dramatic roles in community theater presentations. She repeatedly states that she has "no problems" and wants to be the person in the group who helps everyone else with theirs. She actively exhibits this desire and must be persuaded that this is not her role in this group. As other students express their problems and successes, she gradually becomes courageous enough to share that she feels that she is the family scapegoat and that her alcoholic mother refers to her as the "family whore," complaining "why can't you be like your sister?" Polly states that she has a low rate of sexual activity and feels that her mother is concerned that she will be like she was at her age (very sexually promiscuous). Polly also reports that she is continuously afraid that her dad will "slap her around." Polly's mother visited with the school principal and superintendent and stated that, although she had wanted Polly to be enrolled in the group, she felt now that Polly had "no business being around kids who were bad influences because they have so many problems." Polly's teachers state that she is bright and does not apply her abilities to her work. Polly's goal is to excel in theater.

Tricia

Tricia is an attractive 13-year-old who is mostly interested in boys. She experiences problems with school authorities for smoking on school grounds, tardiness, and her grades. She seldom attends school or the self-esteem class.

Connie

Connie, 14, has a teacher who referred her to the group because he feels she has excellent potential, but does not apply herself to her school work. His perception is that "she chooses the peer group that will get her into trouble." The teacher is pleased that he was able to persuade her to try out for the basketball team and to be successful in that attempt. Connie is a "giggler" and reported that she has tried various drugs and is not now using them, although she occasionally drinks alcohol. She is sexually active. She reports that her parents do not listen to her and

constantly argue loudly in front of her. Her family is upper middle class, and she describes them as "totally focused on religion." Connie's goal is to have the boyfriend she wants.

General characteristics of the students

The students described above have physical appearances similar to other students their age. They are of a variety of ethnic and socioeconomic backgrounds. Some have been classified as having learning disabilities or mild mental retardation. One student in this project was determined to have a legal, severe hearing impairment. Many of the "primary" handicapping conditions were actually secondary to painful emotional overlays. Such students present a variety of "behavior problems" to school personnel. The principal adults in their lives, their parents, have provided for these students to some degree since they were infants. They are the same individuals who tell the children that they love them while frequently abusing them physically, emotionally, verbally, and/or sexually. The students generally feel unlovable and undeserving. Because they are accustomed to abuse and typically feel that it is their fault, their common modus operandi is to set themselves up with abusive peer and other relationships.

They generally exhibit a feeling of inferiority which is frequently unconsciously reacted to by society, including school personnel. For example, sometimes school staff encourage them to find tasks that are "less difficult–more at their level." Their glasses are generally viewed by society as being half empty rather than half full. These students desperately want friends and they want to be "like everyone else." Drugs, alcohol, and sexual relations are frequently used as relief from the reality of their lives.

They are often absent from school, partly because they feel that school is boring and doesn't meet their needs. Many have physical ailments that "come and go." Many of the students are not noticed by the schools or they are noticed because they are "behavior problems." Most school personnel have not been trained to recognize many of the nuances of the behavior of abused children and sometimes feel that the behaviors are totally the child's fault, that the child is a "trouble maker," etc. Many school employees simply do not want to see the extent of the problem because they have not been trained to deal with it and the solutions are not simple.

Most of the students operate in a "victim mode." Accustomed to being victimized at home, they have a very low level of hope that the future could be any different. They usually have inadequate support systems (including overburdened child protective service systems), and a belief that they deserve what has happened to them. Thus, they continue to see themselves as victims–at best, frequently complaining about the state of their lives; at worst, simply programming themselves for more and more disappointments and victimization.

Critical nature of the problem in America

The case studies in this article are typical of far too many students across the U.S. There are *already* several million children who are represented by the above case studies or by worse scenarios (e.g., juvenile incarceration or suicide). It is no longer the atypical student who is sexually active, dreams of dropping out of school, and has used or is using drugs and alcohol. Abusive homes and parents are common in our society. It is now unusual for American children to grow up in a two-parent household. Children now make up the largest segment of America's poor population (Taylor, 1989). The media promulgation of violence and of sexual activity without commitment also contributes to the development of at-risk students.

According to the 1987 report of the Committee for Economic Development, to the extent that our society has so rapidly changed that the rules and structures most of us fondly remember no longer exist, all children are at risk (Hamburg, 1987). "At-risk" students have been defined by the Council of Chief State School Officers (CCSSO) as students who are not likely to successfully

complete high school (Olson, 1987). A substantial proportion of such children are from low income families or do not speak or comprehend the English language. At a minimum, a vast number of students are at risk of not living up to their potential.

In a society in which at-risk students are a rapidly growing population, it is of critical concern that the social institutions ostensibly designed to protect children from abuse and neglect are overwhelmed with referrals. It is not uncommon for a child protective services agency in our country to tell a person calling in a complaint that unless the child's life is in immediate danger (e.g., parental physical abuse, or a suicide attempt), or the child is being sexually abused and the fact can immediately be proven, that a case worker will get to the child "as soon as possible."

It is absolutely imperative to acknowledge that this is the school's and society's responsibility. The American family breakdown has already occurred. Our society has designated schools as the educational authority for children up to 8-1/2 hours a day. Schools have become responsible for education, socialization, and teaching citizenship. Schools must be more than "warehouses." They must lead social change efforts and not merely reflect the radical societal changes that have occurred.

The vast majority of school personnel desire the best possible education for all children. Yet administrators, teachers, and related services personnel are generally not trained to adequately deal with the emotional overlays of at-risk students. Many school personnel are not fully aware that children who are emotionally scarred are unable to learn until their needs are holistically addressed. Educational personnel who are not trained regarding how to appropriately address student needs and involve their families and related community groups will typically hesitate to do so. Besides the fact that at-risk students such as those described above carry life-long scars even when they receive counseling or other treatment, the social dangers of not providing assistance to such students is staggering.

One in six babies born in the United States today is born to a teenage mother. Ninety-six percent of these mothers keep their babies (Hamburg, 1987). The hopelessness and the lack of control of their own lives felt by children such as those in the case studies above are key variables. Social dangers include school dropouts becoming dependent on welfare, and the creation of violent gangs, street people, and drug and alcohol abuse and addiction. The cycle of these social problems is quite vicious. School dropouts, teen parents, and abused children contribute to continued cycles of child abuse, addiction to alcohol and drugs, teen pregnancy, and school dropouts.

Eighty-five percent of America's workforce by the year 2000 will be composed of women, minorities, and immigrants (Taylor, 1989). The economic competitiveness of our country depends on trained, educated employees. With one out of four students in the U.S. dropping out of school, we are at a crisis point for businesses having an adequate supply of trained, educated employees and for America having educated voters (Taylor, 1989).

At-risk students in rural America

There are many ways that, as a result of a disability and/or environmental conditions, rural children are placed at-risk for learning. Rural areas typically have disproportionate percentages of students from poor families, and many rural communities are composed of Hispanic migrants and other non-English-speaking populations. Significant rural populations are also composed of minorities–e.g., those located in Southern Black communities and on Native American reservations.

More than 25% of all high school seniors across the U.S. do not graduate, and many who do need remedial reading and writing courses (Olson, 1987). The statistics are even more grim in rural areas. Whereas one in four American children under the age of six years is living below the

poverty line, in rural areas, 30% of the farm population and 24% of the non-farm population are living in poverty. Rural U.S. citizens are twice as likely as non-rural citizens to be poor (Brown, 1989; National Rural Studies Committee, 1989; O'Connor, 1986), and fewer services are available for at-risk students in rural areas.

The prevalency of at-risk students in rural areas is quite high. For example, the Department of Education in the rural state of Wyoming stated that as many as half of the state's children could be classified as at-risk in terms of their potential for dropping out, suicide, drug addiction, abuse, crime, pregnancy, or illiteracy (Wyoming Department of Education, 1987).

The serious nature of this problem is reflected in the fact that two-thirds (67%) of all schools in the United States are in rural areas, and the majority of unserved and underserved children are located in rural America (Helge, 1984). Problems traditionally associated with implementing comprehensive special education programs in urban areas are compounded in rural areas. Vast land areas, scattered populations, and inadequate services are obstacles to program development, particularly when highly trained personnel and specialized facilities and equipment are required. The isolation of many rural areas, especially those in remote locations with sparse populations, creates conditions favorable to the creation of at-risk children. For example, the lack of services with a preventive emphasis is a key variable.

Rural culture is also a factor. Citizens in small communities essentially "live with" their neighbors. They frequently see them in the grocery store and the post office. A family member may be employed by an alcoholic who neglects his children or is a suspected child abuser. Particularly if the community has inadequate preventive services (those that inform the community of what to watch for and how to successfully–even anonymously–intervene), many citizens may decline to "get involved."

Many factors contributing to at-risk youth are more prevalent in rural areas. E.g., the chances of youth violent death are much higher in parts of the rural West. In some western counties, rates for white males are 13% higher than for poor inner-city youth. Reasons include isolation, high unemployment, absence of extended family, and easy access to firearms. Frank Pauper of Rutgers University believes that the western macho culture is so prevalent that youth feel they must drink, fight, and take physical risks (*USA Today*, November 11, 1987). The increase in youth suicide is related to divorce, poverty, moving, loss of a loved one, and to academic pressures.

Most rural students are confronted with the limited entertainment available in their local community, yet the mass media continuously announces that an unlimited number of exciting options should exist. Thus, it is understandable that alternatives such as illegal drugs, alcohol, and sex frequently become exciting, regular alternatives.

Conditions associated with at-risk students

The at-risk condition is related to multiple societal, environmental, and personality factors. Societal characteristics include violence including in the mass media, the breakdown of the American family, the encouragement of physical punishment, racial discrimination, lack of willingness to be involved (e.g., not "recognizing" child abuse), and inadequate parenting models. Institutional factors include gaps in services offered by community agencies, inadequate numbers and qualifications of child protective services workers, deficiencies in the foster care system, resistance to interagency collaboration, and competition among agencies for service delivery. An additional institutional factor is that educational personnel are typically not trained or encouraged to holistically meet the needs of at-risk students. Environmental factors include poverty, unemployment, and dysfunctional family relationships. Personality factors include rigid thought patterns, growing up in a dysfunctional family system, extreme feelings of inadequacy, and high

control needs combined with low control situations. The characteristics listed in Table I are most frequently associated with children being at-risk for needing special help.

Table I

Characteristics Associated With At-Risk Students

Substance abuse
Involvement with crime
Suicide attempt/depression/low self-esteem
Child abuse (physical, emotional, verbal, and/or sexual)
Poverty
Child of alcoholic or substance abuser
Child in a dysfunctional family system
Illiteracy/English as a second language
Migrant
Handicapping condition
School dropout
Sexually active/pregnant
Minority and poor
Health problem
Performance significantly below one's potential
Residence in a rural/remote area

At-risk students typically are involved with one or more of the above conditions. These conditions are becoming more prevalent and are frequently related to one another. They are correlated with broad social changes across America, including the growing number of dysfunctional families in the U.S. Rural poverty caused by the economic crises of various farm, gas, oil, and wood industries has also contributed. Many at-risk situations are directly related to increased alcohol and drug use in this country. In most rural communities, it is now commonly accepted that a developmental task faced by all adolescents is to come to terms with alcohol, drugs, and sex.

The use of alcohol and drugs during school hours has become common. The major factors related to adolescent drinking and drug use are peer pressure, peer approval, and low self-esteem. The greatest amount of peer pressure is typically applied on school grounds.

Problems are frequently cyclical or are at least compounded. For example, it is well known that children of untreated alcoholics are likely to become alcoholics, teenage mothers are the least likely to receive prenatal care, and the most likely to produce offspring who become teen parents and/or have a disability. Young men and women age 15-18 are in the highest risk group for sexually transmitted diseases (Shalwitz, 1988). The main barriers to teen health care are that it tends to be unaffordable, inaccessible, or inappropriate to the specific needs of adolescents (CDF Reports, 1984). Sexually active teens are at an especially high risk of contracting sexually transmitted diseases or other health-related problems.

Critical factors in adolescent development include the development of coping skills and dealing with issues of identity, self-esteem, and self-image. Adolescence is also a time of resolving issues of dependence and independence. These issues are difficult enough under normal circumstances, but become unduly complicated when the adolescent becomes involved with one of the factors in Table I.

Community services are inadequate even in large urban areas (CDF Reports, 1984). Rural areas typically lack programs concerning family planning, anonymous pregnancy testing, and

supportive efforts for pregnant and parenting teens. Many rural communities such as Appalachia and part of the Midwest farm belt accept and even expect earlier marriages and younger ages of childbirth.

A host of new health trends collectively known as the "new morbidity" are threatening a growing number of teens. These trends include problems with social rather than biological roots, such as alcohol or drug abuse, school dropouts, teen pregnancy and sexually transmitted diseases, violent behavior, suicide, and other health problems. A number of these conditions now are leading causes of death or disability among American youths (CDF Reports, 1984).

Compounding teenage health care problems is the remarkably low utilization of health care services. Teens who do use health services often find that providers are not prepared to deal with their special needs for guidance and structure. Yet health problems tend to be more common among low income teens, in part because conditions are more likely to be untreated or even undetected during childhood.

Community mental health resources are also inadequate in rural America, and the comprehensive roles of school psychologists are frequently misunderstood in rural schools. Qualified rural school psychologists are difficult to recruit and retain, frequently unaffordable for rural schools, and are not well used by school systems and parents. The majority of rural schools do not employ school counselors, largely for financial reasons (Helge, 1985).

Child abuse is a much more serious problem than recognized by most U.S. citizens. The National Center on Child Abuse and Neglect estimates that over one million children are maltreated by their parents each year. As many as 100,000 to 200,000 of these children are physically abused, 60,000 to 100,000 are sexually abused, and the remainder are neglected (Winters, 1985).

For children one to five years of age, abuse is second only to accidents as the cause of death. National studies on prison populations indicate that 80-90% of the inmates have been abused as children. Experts estimate that as many as one out of every four girls and boys have experienced some form of sexual abuse. These figures are shocking, but even more shocking is the fact that for every case of child abuse reported, two more go unreported. Child abuse and neglect occur in every segment of our society–poor, rich, uneducated, and highly educated (Winters, 1985). For the reasons reported earlier, it is often more prevalent in rural than in non-rural areas.

Policy Implications

The complex social factors involved in the creation of at-risk children require social change as well as classroom intervention. The CCSSO recognized this and adopted a proposal calling on states to "guarantee" a high quality precollegiate education to those students deemed least likely to finish high school. This is evidence of the complexity of the factors involved in the at-risk situation. Among the eleven "guarantees" for at-risk students in the CCSSO policy statement is the right to attend a school with a demonstrated record of "substantial and sustained" student progress.

The existence of a disability makes graduation even more difficult (Viadero, 1989) as does residence in a rural area. The private sector, elected officials, and the wider citizenry are clearly recognizing that without success for all children, our standard of living in the United States will significantly decline. This is an important new incentive for effective programming for at-risk children.

The CCSSO concluded that any effective strategy for helping at-risk students will require a team effort on the part of state agencies, business and industry, communities, schools, and parents. More program emphasis should also be placed on prevention and early intervention, and

these efforts should be generic, rather than focusing on a single risk, such as substance abuse. The CCSSO report also stated that nontraditional educational arrangements should be encouraged for at-risk children and youth (Olson, 1987).

The emphasis must be on at-risk students developing self-esteem and leading useful lives--a "directional" versus "correctional" approach. All types of educational personnel must be trained and encouraged to holistically address the needs of at-risk students.

Figure 1 indicates preventive and treatment factors that will assist at-risk students. Social change, such as that recommended by the CCSSO, must be simultaneous with classroom, counseling, and parental involvement efforts. Such an approach will assist students in developing self-respect, motivation, a strong sense of identity and control over their own lives, and responsibility for their own actions.

Preventive and treatment factors to assist rural at-risk students

1. Social change

Social changes should be planned and must recognize the inherent factors in a given rural community. An example would be working with parents and initiating alternative entertainment in a mining or logging camp with a high rate of adult alcoholism and heavy teenage drinking. High school graduates who are successfully farming could be invited to speak to students in a neighboring community where most adults did not complete high school and unsuccessfully continued family farming traditions. Similarly, it would be wise to work with local leaders to have them initiate sex education in a highly conservative community that did not perceive the relationship between teenage pregnancy and lack of sex education. The inherent attributes of any rural community will be both positive and negative, and should be recognized and used. For example, the fact that rural citizens generally know each other and are aware of local happenings could inhibit the courage of a local citizen to become the local "sex educator." It could also increase accountability of curriculum content.

2. Policy change/development

In most instances, there will be no formal policy regarding social problems which contribute to the development of at-risk students. As with social change, it will be best to encourage locally respected citizens to initiate the development or change of policy. In the event that a policy exists, but is obsolete or inappropriate, the challenge will be to motivate local policymakers. Motivation is initiated by discomfort with an existing situation and a realistic expectation that the situation can be improved. It may come from increasing community awareness of social problems, expectations for performance within that community, and/or discomfort with current situations.

3. Appropriate preservice education

Preservice efforts must include education about all of the factors in Table I and in Figure 1. It should emphasize the development of student self-esteem as a preventive and intervention mode. The implications of the factors in Figure 1 for the rural community and how social and policy changes occur in rural America must be understood. This type of education will also assist with the recruitment and retention of qualified rural educators. Educators and related services personnel of all types must be trained to address the emotional needs of at-risk students. Often, intervention regarding a "primary" disability can best occur via addressing the "secondary" disability, the emotional overlay. There must be an understanding that students with serious emotional difficulties are generally unable to focus on learning.

4. Appropriate inservice education

The first priority must be the immediate welfare of the student. Teachers, related services personnel, school board members, administrators, and others must understand that the worst thing they can do is to ignore a student's problem. Each person attending inservice must be encouraged to take their knowledge back to other personnel in the school and to parents. The content should include all of the factors in Table I and Figure 1. Inservice time should emphasize processes of enhancing student self-esteem and include methods of developing interdisciplinary assessment and intervention teams. Teachers and related services personnel should be trained to work with families, community agencies, and with students regarding the emotional needs of at-risk students.

5. Community-business-school partnerships

It is essential that the community, including parents, social agencies, businesses, and civic and volunteer organizations, be involved. Rural resources are simply too scarce to attempt to deal with problems in isolation. All community resources are required to handle social problems such as those involved with at-risk conditions. It is important that all techniques involving community elements preserve student confidentiality.

Vocational education is frequently a "missing element" in effective programming and is an essential element in dropout prevention (National Center for Research in Vocational Education, 1989). Thus, school-business-community partnerships are imperative.

6. Family involvement

Parents are an essential resource in program planning and implementation. They can approach other parents, community groups, and school employees. Siblings can often reach students who will not listen to anyone else. In some cases, families will be in denial (e.g., alcoholism, substance abuse, or attempted suicide). In such cases, the school and community must help parents understand that denial is, in essence, condoning behavior and allowing it to continue to the detriment of the student. It is especially critical to involve parents of students in dysfunctional family situations if at all possible. Frequently, rural family members will listen to their peers (e.g., neighbors, cooperative extension workers, or extended family members) more easily than they will to school personnel. Thus, all natural outreach agencies or unique rural resources should be involved (e.g., mail carriers, grange organizations, 4-H clubs, natural community communicators, cooperative extension, public health workers, etc.).

7. Community education

It is essential that the community be educated regarding all of the factors in at-risk situations. This will assure that many such situations will not recur and will help in ameliorating the current conditions. Community education might occur via town meetings, newspaper articles, presentations at local Welcome Wagons, Garden Clubs, 4-H meetings, or county fairs. Advanced technologies can be used such as satellite training or informational programs regarding recognizing and dealing with factors such as child abuse.

8. Intra-school efforts

These efforts will include problem recognition, development of school policies, interdisciplinary approaches for assessment and intervention, vocational education, and comprehensive transition and counseling programs. Families and other community members should assist with design as well as implementation of programs.

For example, teachers must learn to deal with the more covert/difficult situations such as knowing when students' actions are affected by alcohol or drug use. This might include students whose long-term use of drugs or alcohol has left them without motivation for learning, or students who are so depressed that they are simply biding time until the school drops them, they quit school, or they attempt suicide. Symptoms such as high absenteeism, frequent tardiness, amotivational syndrome, manipulative behavior, mood swings, and denial must be dealt with even though they are difficult. To follow a student's lead and buy into the denial of students' parents or other teachers is to condone this behavior and allow it to continue to the detriment of the student and the general school community.

An effective student assistance program should be established in which teachers and related professionals become part of an assessment team that looks at the behavior of students who are having difficulty in school. Health, absenteeism, change in performance, and classroom conduct are among the behaviors that should be evaluated. School personnel must be trained and supported regarding recognizing and reporting child abuse.

Assessment processes should be completed by the student's teachers, counselor, nurse, other related services personnel, administrator, and parents (when possible). This gives the assessment team a tool with which to evaluate the student. This information will more readily enable the school to address with parents the issues involved in the at-risk situation. This type of confrontation or intervention will be helpful in breaking through both parent and student denial.

Self-esteem enhancement must be emphasized. Students must be supported. Teachers and related services personnel must be adequately trained and supported as they holistically address student needs, and work with families and community agencies. The administration and school board must adopt a strong policy and set guidelines for addressing at-risk conditions such as low self-esteem, poverty, illiteracy (or English as a second language), active teenage sexuality, substance abuse, and crime. It must also be recognized that just as an alcoholic or addict moves through the phases of transition--denial, anger, bargaining, and depression--before reaching acceptance, so do teachers, counselors, administrators, and parents. Efforts must be persistent and encouragement must be offered, recognizing that at-risk conditions will not go away as long as schools are trapped in denial.

9. Community mental health services

As mentioned previously, rural areas typically have inadequate community mental health services. Efforts must be made to upgrade the preventive and treatment aspects of such services. In addition, in remote areas and others lacking such services, advanced technologies or other methods of expanding services available in the region must be made. This may include a circuit-rider system of mobile/itinerant personnel or the use of alternate transportation to take clients to services (e.g., private pilots or the use of the transportation systems of regional businesses). Use of existing rural outreach systems (e.g., cooperative extension workers, bookmobiles, or public health workers) would be consistent with local community values and potentially helpful.

10. Comprehensive community health services

These services must also be upgraded to include prevention as well as treatment. This means that services for children of alcoholics, students with low self-esteem, students with previous experience with alcohol and drugs, and sexually active teenagers must have preventive aspects. Pregnant teenagers, alcoholics and substance abusers, students who attempted suicide or experienced severe depression, juvenile delinquents, dropouts, and students with sexually transmitted diseases, must also be serviced via a treatment mode. Self-esteem education is the critical prevention and treatment variable for at-risk students. Students are frequently told they will not succeed, in subtle and/or direct ways, at home and at school. Their psyches must be strong

enough to cope with whatever dysfunctional circumstances are part of their lives, and to assertively plan a positive future for themselves.

Conclusions

As social changes occur, the number of students at-risk is increasing. Systematic approaches of preventing and ameliorating at-risk situations are essential and will save social anguish and tax dollars. Appropriate preservice and inservice education, community-business-school partnerships, family involvement, and community education must complement intra-school approaches of working with at-risk students. Community health and mental health services must also be upgraded so that the needs of rural students are addressed. These approaches must be designed after considering the contexts of specific rural communities.

Preventive and Treatment Factors to Assist Rural At-Risk Students

Inputs	*Lead to:*	*Student Products*
Social change, recognizing local rural cultures		Healthy self-esteem
Policy change/development		Self-nurturing
Preservice education		Sense of identity
Inservice education		Internal motivation
Community-business-school partnerships		Sense of responsibility for actions
Intra-school efforts Problem recognition Development of school policies (with community participation) Interdisciplinary, holistic intervention approaches Assessment Emphasis on self-esteem enhancement Vocational education Counseling Transition programs Family involvement		Control over one's own life Ability to find appropriate external support systems
Community mental health services Prevention Treatment		
Comprehensive health services Prevention Treatment		

Figure 1

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